
MEDICAID ELIGIBILITY
FORMS AND INSTRUCTIONS

DOM-333 - REQUEST FOR WORKERS' COMPENSATION COMMISSION DATA

PURPOSE & USE

This form is used to verify Workers' Compensation benefits as a result of an on the job injury. If a possibility of workers' compensation benefits exists, this form is completed by the Specialist and submitted to the State Office Eligibility Division along with a signed/dated DOM-301, Authorization to Release Information, signed by the client.

All inquiries must come through the State Office so that an Eligibility Division staff member can take it to the Workers' Compensation Commission for completion. The Workers' Compensation Commission will not fill individual written requests from Regional Offices.

INSTRUCTIONS

Prepare an original and 1 copy. Mail the original to the State Office Eligibility Division and retain the copy in the record until the original is returned. Include all identifying information on the client, including a workers' compensation claim number, if known.

Part II will be completed and returned by the State Office after verifying the information at the Workers' Compensation Commission.

REQUEST FOR WORKERS' COMPENSATION COMMISSION DATA

TO: Medicaid State Office, Eligibility Division

FROM: _____ Regional Office

We have received an application/redetermination form for Medicaid from the following person. On this form, he/she stated that a claim was filed with Workers' Compensation. Please check with the Mississippi Workers' Compensation Commission to acquire the information in Part II. We have enclosed a release signed by the applicant/recipient to authorize the Workers' Compensation Commission to release this information to an authorize representative of Mississippi Medicaid.

Date

Medicaid Specialist

PART I

Name of Applicant/Recipient: _____

Address: _____

Social Security Number: _____ Medicaid ID Number: _____

MWCC Claim Number: _____

Employer at Time of Accident: _____

Address of Employer: _____

Date of Injury: _____

PART II

Weekly Benefit Rate _____ Maximum Number of Weeks Payable _____

Date of Initial Payment _____ Medicaid Payments _____

Date and Amount of Lump Sum Payment, if applicable _____

Amount of lump sum payment that goes towards: Doctor's bills, \$ _____;

Lawyers fees, \$ _____; Hospital bills, \$ _____; Other, \$ _____; \$ _____.

No Claim _____

Claim in Process _____

Claim Disallowed _____

Area Supervisor